patients were analyzed to identify subgroups of patients regarding potential for DDI and antipsychotic treatment costs. **RESULTS:** Of 8221 schizophrenia patients identified in the data base 28.2% had co-prescriptions with potential for DDI and were regarded as subgroup for well directed use of PER. The average antipsychotic costs/quarter of these patients were €399.0/patient for atypicals; €276.5/patient for generic and €613.2/patient for patent protected atypicals (incl. PER). The average treatment costs/quarter for PER were 551.0 EUR/patient. PER treatment of all patients treated with patent protected atypicals at risk for DDI would reduce the overall antipsychotic expenditure for schizophrenia by 1.9%. PER treatment of all atypical patients with potential DDI would increase the schizophrenia antipsychotics budget by 8.0%. **CONCLUSIONS:** The budgetary impact of well directed used PER is limited by the share of schizophrenia patients with potential DDI. As PER is associated with 10% lower treatment costs compared to patent protected atypicals, PER could reduce costs if used instead of other patent protected atypicals. Reduced risk for DDI complications with PER may lead to additional cost savings that are not captured in this analysis.

PMH15

COSTS OF DEMENTIA IN HUNGARY

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OBJECTIVES: To investigate the costs of dementia in Hungary, analyzing the distribution of direct and indirect costs, considering also the costs of caregivers. On basis of prevalence estimations from previous dementia studies we extrapolated the mean cost issues and estimated the burden of dementia for the population aged >50 in Hungary. **METHODS:** A cross-sectional study of 88 consecutive patients with dementia and their caregivers was conducted in 2008 involving physicians and nurses of 3 GP and 1 outpatient practices. Resource Utilization in Dementia (RUD), Mini Mental State Examination (MMSE), and the health related quality of life EuroQoL (EQ-5D) questionnaires were applied. Using 2007 prices we established the proportion of the main cost-drivers and categorized cost-data by patients' age and MMSE scores. **RESULTS:** Patients (59% female) were involved with clinical characteristics of mean MMSE 16.7 (SD 7.24), EQ-5D 0.401 (SD 0.327.), 59% were female, mean age was 78 years (SD 8.5). The average monthly direct costs per patient were 282 (SD 532) euros, mean indirect costs were 53 (SD 187) euros/patient/month. Total costs by age-groups (total sample, 65–74, 75–84 and 85 or more years) considering mental status (MMSE score level of 0–18, 19–24 and 25–30) within each were 176, 234, 108, 131 and 375, 588, 166, 67 and 418, 569, 262, 121 euros/patient/month, respectively. Dementia-related health services and indirect costs (income loss of caregivers) had the highest shares of the whole, 32%–32%for both. **CONCLUSIONS:** Costs of increase by age and severity of the disease (measured by MMSE scores). At national level, in 2008 the estimated direct costs of dementia were 255 million euros with 48 million euros indirect costs. Trends show a remarkable growth in the number of the demented patients. Therefore, an increase of disease burden of dementia is expected in the future.

PMH16

COST-BENEFIT ANALYSIS OF FOUR ANTIPSYCHOTIC DRUGS FOR THE TREATMENT OF SCHIZOPHRENIA IN COLOMBIA

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OBJECTIVES: To compare, through cost-benefit analysis, a long-acting atypical antipsychotic (risperidone) with two second-generation oral antipsychotics (olanzapine and clozapine) and a "typical" prolonged action antipsychotic (pipotiazine). **METHODS:** We designed a decision tree that included only direct costs, from the third party payer perspective and a single year time frame. Main epidemiological variables, obtained mostly from international literature and clinical trials, were adherence, relapses with and without hospitalization, and side effects. Local costs were obtained from Colombian health insurers and providers. **RESULTS:** According to the model, the use of long acting risperidone injection was associated with the lowest overall costs to the system (US$5169 per year) followed closely by clozapine (US$5221) whose long term metabolic effects were not included in the model. Either one of these drugs would save around US$ 800 per year when compared with olanzapine (US$6087), and more than US$1000 when compared with pipotiazine (US$6544), the least expensive of the group and currently the standard of care in most patient groups. **CONCLUSIONS:** Despite their apparent higher costs, atypical antipsychotics can be cost saving through their reduction in relapses and hospitalizations. The economic benefit, particularly with risperidone injection which had the lowest side effects, would be added to the direct and indirect benefits to the patients and their communities due mainly to relapse reduction.

PMH17

HEALTH CARE COSTS ASSOCIATED WITH TREATMENT OF BIPOLAR DISORDER USING A MOOD STABILIZER PLUS ADJUNCTIVE ARIPIPRAZOLE, QUETIAPINE, RISPERIDONE, OLANZAPINE OR ZIPRASIDONE

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OBJECTIVES: Bipolar disorder has an associated economic burden due to its treatment, including medication and hospitalization costs as well as costs associated with treatment of comorbid medical conditions. This study compared health care costs in patients treated with a mood stabilizer and adjunctive aripiprazole versus adjunctive olanzapine, quetiapine, risperidone or ziprasidone. **METHODS:** A retrospective propensity score-matched cohort study was conducted in the LabRx integrated claims database from January 2003 through December 2006. Patients aged 18–65 years with bipolar disorder and 180 days of pre-index enrolment without atypical antipsychotic therapy and 90 days post-index enrolment were eligible for inclusion. Mood stabilizer therapy was initiated prior to index atypical prescription. Generalized gamma regressions were used to compare the total health care costs of patients treated with adjunctive aripiprazole and patients treated with adjunctive olanzapine, quetiapine, risperidone or ziprasidone. **RESULTS:** After controlling for differences in baseline characteristics and pre-index cost, psychiatric costs and subtotal psychiatric and general medical cost were significantly higher for all adjunctive atypical antipsychotics than adjunctive aripiprazole ($p < 0.001$). There was no significant difference in general medical costs between aripiprazole and ziprasidone, olanzapine, or quetiapine. Aripiprazole medication costs were significantly higher than for quetiapine and risperidone ($p < 0.001$) but not olanzapine or ziprasidone. Total health care costs were significantly higher for ziprasidone, olanzapine, or risperidone ($p < 0.001$) than aripiprazole but not for quetiapine. **CONCLUSIONS:** Adjunctive aripiprazole may have economic benefits over other atypical antipsychotics in terms of lower psychiatric treatment costs of care than adjunctive olanzapine, quetiapine, risperidone or ziprasidone, and lower total health care costs than adjunctive olanzapine, risperidone or ziprasidone.

PMH18

HEALTH CARE RESOURCE UTILIZATION ANALYSIS OF PRE/POST LONG-ACTING RISPERIDONE IN THE TREATMENT OF SCHIZOPHRENIA AND SCHIZOAFFECTIVE DISORDERS IN THREE REGIONAL PUBLIC HOSPITALS IN HONG KONG

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OBJECTIVES: The objective of this study was to compare the health care utilization and associated cost in a group of schizophrenia and schizoaffective patients pre and post risperidone long-acting injection (RLA) treatment. **METHODS:** This was a retrospective cost analysis study. Data was gathered solely from hospital records, which were reviewed for data pertaining to utilization of health care resources. The study was performed from a public health care institute's perspective. Patients studied were from three public hospitals in Hong Kong. They were started on antipsychotic treatment but later on switched to RLA therapy due to adverse effects, poor response or whatever reasons and remained on risperidone for a minimum of 12 months. The initial RLA administration date served as the index date. Study periods included 12-month pre and 24-month post the index date and patients served as their own control. Cost data collected included medications, laboratory procedures, other more sophisticated investigational procedures (e.g. CT, MRI), regular and extra outpatient clinic visits, emergency room utilization, hospitalization, and other health services such as special counseling sessions. **RESULTS:** A total of 180 patients who received RLA treatment were identified from 2 public general and 1 psychiatric hospitals in Hong Kong over the period of 2003–2006. The overall annual cost of treatment before and after RLA injection was HKD80.5 million (USD10.3 million; 1USD = 7.8HKD) and HKD26 million (USD3.34 million) respectively. The annual average cost per patient before and after RLA treatment was HKD447,300 (USD57,300) and HKD144,600 (USD18,500) respectively. **CONCLUSIONS:** From the present group of patients assessed two years after initiation of RLA treatment, it appears that the treatment can potentially lead to substantial cost savings. The major cost driver appears to be hospitalization due to either poor control or adverse effects of medications.

PMH19

ECONOMIC ASSESSMENT OF SECOND-LINE TREATMENT: SWITCHING FROM A GENERIC SSRI TO ESCITALOPRAM, AN SNRI, OR ANOTHER GENERIC SSRI BY PATIENTS WITH MAJOR DEPRESSIVE DISORDER (MDD)

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OBJECTIVES: First-line treatment of MDD patients with a generic SSRI is often encouraged by managed care organizations. However, some patients may require second line therapy. This study evaluates the economic consequences associated with three options of second-line treatment: escitalopram, an SNRI (venlafaxine or duloxetine), or a generic SSRI. **METHODS:** Adult MDD patients treated with a generic SSRI were identified in the Ingenix Impact database (2003–2007) and included if they switched to escitalopram, an SNRI, or another generic SSRI. Urgent care utilization during the 3-month follow-up was compared across these three study cohorts. Costs incurred during three months pre- vs. post-switching date were compared descriptively and using regression analyses adjusting for patient demographics, comorbidities, prior resource use and length of therapy. **RESULTS:** The study identified 7,774 switchers to escitalopram, 10,505 to SNRIs, and 6,723 to a generic SSRI. Compared to escitalopram switchers, patients who switched to an SNRI or a generic SSRI had an increased adjusted risk of mental health-related urgent care utilization (OR = 1.30 and 1.17 respectively, both $P < 0.05$). Patients who switched to escitalopram had a $402 reduction in medical costs ($P < 0.001$) during the 3-month follow-up period compared to